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NHS Sheffield Clinical Commissioning Group

Guidance on Transcribing Medication Details onto MAR Charts

All service users require a Medication Administration Record (MAR) chart in order to provide a record of administration of medication. MAR charts are usually issued by the pharmacy supplying the routine medication, though there are occasions when interim medication will have to be handwritten onto the MAR chart by care home staff. Transcribing should only be undertaken by members of staff who have been deemed competent by the care home manager.

This guidance supports consistency and reduces potential risk of error when transcribing. It also supports the recommendations in NICE SC1 Managing Medicines in Care Homes and the principles within the RPS and RCN document - Professional Guidance on the administration of medicines in health care settings.

What does transcribing medication mean for care homes?

Transcribing medication is the action of copying details of prescribed medication onto the MAR chart. It should not be confused with prescribing. In the majority of cases the **pharmacy label will act as the primary source of information** but for reconciliation purposes **a second source must be used**. It is important to ensure the pharmacy label affixed to the medicine has been dispensed within the last 3 months (with the exception of when required 'prn' items that may have been dispensed at an earlier date).

The following list provides examples of what could be used as a secondary source to check against the pharmacy label:

- An original prescription written by a prescriber from primary care, which may be the right hand side/counterfoil of the **current** prescription or a secondary care discharge letter;
- A printed or written record obtained from the service user's GP detailing current prescribed medication e.g. Summary Care Record or Summary Patient Record;
- A copy of the current MAR chart from the previous care home/setting;
- An online ordering system linked to the GP practice showing an up-to-date medication list.

In the absence of any pharmacy labels it is still recommended to obtain two sources of information. Where appropriate, confirm with the service user if the information is correct as there may have been recent changes not highlighted on any documentation.

It may also be feasible to obtain verbal confirmation from the GP or other health care professional e.g. pharmacist. However, verbal confirmation should be treated with extra caution as there is an inherent risk when discussing medicine regimens. **It is not advisable to rely on verbal confirmation alone as the only source of information.**

If verbal confirmation is used, then it is important to:

- Ask for confirmation of the service user's name and date of birth
- Ascertain the credentials of the person imparting the information. This should be a registered health care professional with their credentials recorded in the service user's notes and MAR e.g. verbally confirmed with Dr A Smith (GMC:1234567) 01/01/21 – *Nurse/Carer Name(s)*
- Name and strength of each medication
- Dose and frequency
- Form of administration
- Route of administration
- Time of administration
- Duration

The above should then be **repeated back** to confirm. Particular attention should be taken with high-risk medicines such as insulin, anticoagulants, cytotoxics, or controlled drugs. It is advisable to involve another authorised member of staff in the verification process.

Transcribing may be required by care home staff when there is:

- emergency admission to the care home;
- planned discharge from hospital if medication is changed;
- medication prescribed during an interim visit e.g. antibiotics.

Where there are concerns about the safety of transcribing then medical advice must be sought before medicines are transcribed or administered. This may be due to:

- the quality of the information available is unclear;
- a discrepancy between the information and the medication provided;
- any additional medicines (e.g. bought over the counter or herbal medications) not listed in the medication source;
- clarification needed around whether the medicine is still needed/current.

This must be documented in the service user's notes.

When medication accompanies the service user to the care home

Check that the medicines are 'fit for purpose' i.e.

- the pharmacy label includes the service user's name;
- the name of the medicine on and inside any packaging matches that on the label;
- the medication has not exceeded the expiry date;
- the pharmacy label on the packaging is clear and gives specific instruction on its use.

Transcribing Process

A member of care home staff who has been deemed competent by the care home manager should carefully transcribe the details onto the MAR chart. Clearly annotate the MAR chart so that it is clear when the medication is started within the monthly cycle and, if applicable, when it should be stopped (see Example 1 - Care Home Antibiotic)

Particular care should be taken in transcribing details of high-risk medicines such as insulin, anticoagulants, cytotoxics, or controlled drugs.

Transcribing the medication details onto a **paper MAR chart**:

- All information must be handwritten legibly in black or blue indelible ink;
- The service user's full name and date of birth should be clearly written on all MAR charts;
- All medicine names and instructions must be written in full, as printed on the pharmacy label or from other source;
- The following medication details must be stated:
    - name;
    - route of administration;
    - form e.g. tablets, capsules;
    - strength (N.B. attention to **milli**grams/ **micro**grams – this should be written in full);
    - time of administration;
    - dose and frequency;
    - duration of treatment, indicate short course start and finish date on the MAR chart (if known or applicable).

- Any special instructions and advice labels e.g. take with or after food, disperse in water, may cause drowsiness, should be included;
- Any advice label or warnings, that cannot fit on the MAR chart should be highlighted, for example, by adding **see advice label**;
- The transcriber must sign and date each item and print their name along with their signature on the MAR chart or equivalent documentation;
- If a service user needs more than one MAR chart, each chart should be clearly marked on the front 1 of 2, 2 of 2 etc;
- Details of any allergies or intolerances must be stated in the space indicated. Record if none are known;
- The quantity of each medication received should be recorded;
- Record/attach medication source to the MAR chart to allow GP or others to check;
- Record transcription in services user's care plan, documenting sources used and their date;
- If informed verbally by the prescriber of any dose change or if a medication is stopped, then the MAR chart must be altered accordingly and checked by another member of staff. The original entry must not be altered, instead it should be crossed through, stating the date of change and, if applicable where the new entry is found. A new entry should then be created. If the dose has changed and the original supply is required to fulfil this change, the pharmacy label on the medication will need to be marked "See new directions on MAR". Written confirmation of the change must be requested from the prescriber to verify this and retained with the service user's records;
- Any incidents and near misses identified as a result of the transcribing process should be reported through the normal process.

See Page 4 for examples of transcribing.

Where **electronic MAR (eMAR)** systems are in use the same principles as those used with paper MAR charts should be applied to allow for an accurate and safe transcribing process. Particular care should be exercised with barcode scanning to ensure the correct medicine is 'scanned' to the service user's eMAR.

Checking

The transcription **must** be checked by a second competent member of care home staff as soon as possible. The 'checker' must ensure the sources of information used match the transcription. The 'checker' must also sign and date against each item and print their name along with their signature on the back of the MAR chart.

Seek medical advice if any discrepancy cannot be resolved between the transcriber and checker. It is good practice to liaise with the GP to check and endorse the transcribed entries on their next visit or through other opportunities e.g. scan the transcribed MAR and send via secure email to the surgery.

Staff administering transcribed medicines

If there is any uncertainty regarding accuracy or appropriateness of transcribed medicine, then the staff member administering must seek clarification from the transcriber. If there is still uncertainty, advice must be sought from the GP.

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Approved by: Medicines Safety Group July 2021 **Review date**: **July 2023**

Example 1: Acute Interim Supply

Acute interim antibiotics should be transcribed as per below

Medication Administration Record

Name ANNETTE CURTAIN		**DOB** 25/12/1923	**Allergies** NONE KNOWN	
Address WUTHERING HEIGHTS Room number care home 3				
Doctor Dr ZHIVAGO	**Start date** 03/06/2020	**End date** 07/06/2020	**Start day** Wednesday	
	Commencing	**Wk1**	**Wk2**	**Wk3**

		1	2	3	4	5	6	7	8	9
Medication profile	**Time:dose**									
Flucloxacillin 500mg capsules ONE to be taken FOUR times a day an hour before food or two hours after food space doses evenly throughout the day ** see advice label** MB 03/06/2020 JS 03/06/2020	7:30 AM									
	11:30 AM									
	3:30 PM									
	7:30 PM									

Dr sig.		Carried forward	0			
Commenced		Route ORAL	Rec'd	Quantity 20	by JS	by

Start date matches current cycle

5 day course indicated, rest of the days blanked out

Times on the MAR chart are away from meal times

If there is no space to add printed names then this should be recorded elsewhere so a clear audit trail is in place

Keep out of sight and reach of children
20 Flucloxacillin Capsules 500 mg

ONE to be taken **FOUR** times a day for 5 days

Space the doses evenly throughout the day. Keep taking this medicine until the course is finished, unless you are told to stop. Take this medicine when your stomach is empty. This means an hour before food or 2 hours after food

Annette Curtain **03/06/2020**

Toytown Pharmacy,
Noddy Hill, tel 1234567

Example 2: Regular and 'when required' (PRN) dosing

The regular dose and 'when required' dose are entered separately on the MAR chart

Medication Administration Record

Name ANNETTE CURTAIN		**DOB** 25/12/1923	**Allergies** NONE KNOWN
Address WUTHERING HEIGHTS Room number care home 3			
Doctor Dr ZHIVAGO	**Start date** 04/06/2020	**End date**	**Start day** Thursday
	commencing	**Wk1** 1 2 3 4 5 6 7 **Wk2** 8 9	**Wk3** **Wk4**
Medication profile	**Time:dose**		
Clonazepam 2 mg tablets HALF a tablet to be taken at NIGHT MB 4/6/2020 JS 4/6/2020	10:00 PM		
Dr sig.	Carried forward 0		
Commenced	Route ORAL	Rec'd Quantity 100 by MB	Returned/destroyed

Medication profile	**Time:dose**
Clonazepam 2 mg tablets ONE to be taken THREE times a day when required to control seizures MB 4/6/2020 JS 4/6/2020	

Keep out of sight and reach of children
100 Clonazepam Tablets 2 mg

HALF a tablet to be taken at NIGHT and **ONE** to be taken THREE times a day **when required** to control seizures

This medicine may make you sleepy. If this happens do not drive or use tools or machines. Do not drink alcohol

Annette Curtain **04/06/2020**

Toytown Pharmacy,
Noddy Hill, tel 1234567

Regular dosing recorded as normal

PRN dosing recorded separately

If there is no space to add printed names then this should be recorded elsewhere so a clear audit trail is in place